STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005075	A. BUILDING: _____ B. WING _____	07/22/2015

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ST VINCENT HOSPITAL & HEALTH SERVICES	2001 W 86TH ST INDIANAPOLIS, IN 46260

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S 000	INITIAL COMMENTS This visit was for the investigation of a State hospital complaint. Complaint Number: IN00161031 Substantiated: A deficiency related to the allegations is cited and an unrelated deficiency is cited. Date: 7-22-15 Facility Number: 005075 QA: cjl 09/02/15	S 000		
S 322	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. This RULE is not met as evidenced by: Based on document review and interview, the governing board failed to ensure its restraint or seclusion policy/procedure was followed for 1 of 6 medical records (MR) reviewed (patient 27).	S 322		

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S 322	Continued From page 1 Findings: 1. The policy/procedure Restraint or Seclusion (approved 1-14) indicated the following: "Each episode of restraint or seclusion use, including circumstances leading to use, must be documented in the medical record with plan of care modified ...the type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective. The rationale for the type of intervention selected must be documented in the medical record ...time of discontinuance of restraint must be documented ...Restraint Use for Assaultive and Violent Behavior ...Upon initiation of restraint or seclusion, the patient must be informed of behavioral criteria for discontinuing restraint or seclusion and, whenever possible, receive assistance to meet these criteria. The criteria, patient notification of criteria and assistance provided to the patient must be documented in the medical record. When restraint or seclusion is used for the management of violent or self-destructive behavior, the patient must be seen by a physician or nurse practitioner within one hour of initiation of the intervention. The following must be assessed during this evaluation and documented in the medical record. 1.) The patient's immediate situation 2.) The patient's reaction to the intervention 3.) The patient's medical and behavioral condition 4.) The need to continue or terminate the restraint or seclusion ...The one hour evaluation may also be conducted by an RN or Physician Assistant (PA) who has received training to conduct this evaluation ...When restraint or seclusion is used to manage violent or self-destructive behavior jeopardizing the physical safety of the patient, the order must be renewed in accordance with the	S 322		

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S 322	Continued From page 2 following time limits: 1.) every 4 hours for adults 18 years of age or older ...If the RN assessment determines the need for restraint or seclusion to extend beyond the time limit of the original order as specified above, a verbal/telephone order must be obtained. Continued restraint or seclusion is limited to the time frames listed below: 1.) Adults 18 years of age or older = one (1) additional 4 hour period for a maximum of 8 hours in restraint or seclusion ...If the need for restraint or seclusion extends beyond the time frames noted in (B.) above, the physician or nurse practitioner must see and reevaluate the patient before issuing continued orders for restraint or seclusion: 1.) At least every eight (8) hours for adults 18 years of age or older ... Violent Restraint or Seclusion Monitoring and Documentation Requirements ...The RN will assess the patient upon initiation, hourly, and upon release. Assessment and documentation include vital signs ...level of self control ...continued clinical indications for use of restraint or seclusion ...physical and psychosocial status and comfort ...readiness for release from restraint or seclusion ...a debriefing about the restraint or seclusion episode will occur with the patient, staff, and family (if appropriate) no later than 24 hours after the initiation of the restraint or seclusion episode ...this debriefing must be documented in the medical record ..." 2. The MR documentation for patient 27 failed to indicate the circumstances leading to the use of restraints including a description of the patient's escalating agitation and aggressive or violent behaviors that supported the selection of four point restraints as the least restrictive method of restraint. 3. The order on 12-08-14 at 2259 hours for 4	S 322		

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S 322	Continued From page 3 point restraints due to violent, self-destructive behavior and on 12-09-14 at 0257 hours and 0649 hours by physician assistant PA35 indicated a generic stem statement as the reason for use of restraints: "the immediate threat of injury to others or to self ..." and failed to identify a deliberate patient action or behavior(s) that was reasonably certain to result in injury without immediate intervention as seen in the non-violent restraint orders for patient 27 on 12-08-14 at 0841 hours by nurse practitioner NP31 (patient behavior described as "attempting to remove the medical device" and "inability to follow safety measures/instruction" and in the restraint orders for violent behavior for patient 27 on 12-09-14 at 1133 hours by nurse practitioner NP31 (patient behavior described as "decreased agitation (motor activity), patient able to control behavior and cope with the environment". 4. The MR documentation by nurse N42 and nurse N44 failed to indicate that patient 27 was notified of any behavioral criteria that would result in discontinuing the restraints when satisfied. The restraint order on 12-09-14 at 1133 hours by nurse practitioner NP31 indicated the following behavioral criteria for release of restraints: "decreased agitation (motor activity), patient able to control behavior and cope with the environment" and no MR entry indicated that the nurse N44 was aware of the newly established criteria for discontinuing the 4 way restraints for violent behavior or notified the patient of the criteria to be met for releasing the restraints. 5. The MR failed to indicate the patient was examined by a physician, licensed independent provider (LIP), Registered Nurse or Physician Assistant trained to conduct the evaluation within one hour of the initiation of the restraint ordered	S 322		

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S 322	Continued From page 4 by physician assistant PA35 on 12-08-14 at 2259 hours to document the immediate situation, the patient's response to the situation and current mental and physical condition, and the need to continue or discontinue the restraint. 6. During an interview on 7-22-15 at 1400 hours, the director of quality A2 confirmed the MR failed to document a face-to-face evaluation by a physician or LIP within one hour of the initiation of the restraint on 12-08-14 at 2259 hours. 7. The MR failed to indicate the patient was re-evaluated on 12-09-14 at 0700 hours by a physician, licensed independent provider (LIP), or Physician Assistant (PA) after 8 hours from the initial restraint application on 12-08-14 at 2259 hours before issuing continued orders for restraints. 8. On 7-24-15 at 1657 hours, the director of quality A2 confirmed the MR failed to document a physician or LIP examined and re-evaluated the patient after 8 hours from the application of restraints for violent or self-destructive behavior before issuing continued orders for restraints. 9. The MR documentation by nurse N44 failed to indicate the criteria for discontinuing the 4 way restraints for violent behavior identified in the order on 12-09-14 at 1133 hours by nurse practitioner NP31 (decreased agitation (motor activity), patient able to control behavior and cope with the environment) and failed to indicate that the patient met the criteria for removing the restraints or document the time of restraint removal to demonstrate compliance with time limits per facility policy and federal regulations. 10. On 7-24-15 at 1647 hours, the director of	S 322		

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S 322	Continued From page 5 quality A2 indicated the electronic MR documentation fields for restraint data entry were discontinued at 1340 hours on 12-09-14 and confirmed that no documentation in the MR for patient 27 by nurse N44 or other registered nurse indicated the criteria for removing the restraints, indicated the patient met the criteria for removing the restraints, or indicated that the restraints were removed from the patient around the time the documentation fields for restraint data entry were discontinued. 11. The MR failed to indicate that a patient debriefing including the patient, staff, and family (if appropriate) was conducted no later than 24 hours following the initiation of restraints and documented in the MR per facility policy. 12. On 7-24-15 at 1657 hours, the director of quality A2 confirmed the MR failed to document a patient debriefing was conducted within 24 hours of the initial restraint order for violent or self-destructive behavior.	S 322		
S 732	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4) (d) The medical record shall contain sufficient information to: (1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results. This RULE is not met as evidenced by:	S 732		

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S 732	Continued From page 6 Based upon document review and interview, the facility failed to follow its policy/procedures and ensure that the medical record (MR) contained sufficient information to accurately document the course of treatment and results for 1 of 6 MR reviewed (patient 27). Findings: 1. The policy/procedure Medical Record Requirements (approved 2-15) indicated the following: "The purpose of the medical record is to ...justify the patient's care, treatment, and services, document the course and result(s) of the patient's care, treatment, and services. ...required components of the medical record ...observations relevant to care, treatment, and services ...[and] ...the patient's response to care, treatment, and services ..." 2. The MR documentation by physician assistant PA35 or by staff nurse N42 failed to indicate a description of the patient's agitation and aggressive or violent behaviors that escalated to a need to use four point restraints as the least restrictive method of restraint. No MR documentation indicated an aggressive or violent behavior (grabbing, hitting, or pushing staff or visitors, verbal threats of harm to self, staff, or visitors, attempts or actually causing injury to self or others, damaging fixtures or furniture, etc) exhibited by the patient prior to the application of restraints and no MR documentation indicated an event involving multiple staff members including security personnel to physically restrain the patient. 3. On 7-24-15 at 0820 hours, the director of quality A2 was requested to provide documentation by the physician assistant PA35 or	S 732		

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S 732	Continued From page 7 the staff nurse N42 indicating the behaviors exhibited by the patient for the time period prior to the use of restraints on 12-08-14 at 2300 hours. 4. On 7-24-15 at 1647 hours, the director of quality A2 indicated the only behavioral observations identified in the MR around the time of 4 way restraint application was the description of patient behaviors by nurse N42 on 12-08-14 at 2345 hours after the restraints were applied and confirmed no other documentation of patient behaviors prior to the application of the restraints was available.	S 732		